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Information

Munchausen Syndrome Presenting as Urolithiasis

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BARON KARL FRIEDRICH HIERONYMOUS VON MUNCHAUSEN'S confabulations and peregrinations have been recorded and embellished by Rudolph Eric Raspe.[1] Allegedly, the Baron (1720-1791) traveled through the Continent and England in the late 18th century entertaining many fellow tavern dwellers with his tall tales. A syndrome of factitious illness, convincing (though often self-inflicted) signs of disease and wandering from hospital to hospital has been named after the Baron: the Munchausen syndrome.[2] Though the literature is replete with examples of this syndrome, the presenting signs and symptoms infrequently involve the urinary system. Factitious hematuria with or without the association of renal colic has been reported in ten cases,[3-8] the presentation of a "passed" synthetic renal calculus has been reported in three.[9-11] Herein we will present four additional cases and discuss some common factors shared by them and the Munchausen syndrome in general.

Reports of Cases

CASE 1. A 22-year-old white naval enlisted man was admitted with a 12-hour history of left colicky flank pain associated with smoky colored urine. He later reported pain radiating down into the left testicle with nausea, vomiting and fever. Past urological history showed a left pyelolithotomy via a transabdominal approach for an obstructing "black, radiolucent stone" two years earlier. One year before the present admission another "small black radiolucent stone" on the left side was passed spontaneously. One month before admission, studies had been done for left flank pain and a low grade fever in Vietnam and later the patient was transferred to a military hospital in the United States. The patient stated he was allergic to propoxyphene, morphine, atropine and urographic contrast material—the latter causing hypotension.

On physical examination the body temperature was 39°C (102.2°F) and pulse rate was 72. Examination of the abdomen showed pronounced left upper quadrant, left lower quadrant and left costovertebral angle tenderness; a midline abdominal scar; right lower quadrant scar; right inguinal scar, and left flank scar. The following laboratory findings were recorded: leukocyte count, 8,600; normal values for serum calcium, phophorus and uric acid; 15 to 20 red blood cells per high power field on analysis of urine. A kidney, ureter and bladder study showed no abnormalities.

Cystoscopy and left retrograde pyelogram were done and findings were normal. Urine culture from the left ureteral catheter showed no growth. Subsequent telephone conversation with personnel at a regional naval hospital showed that the patient had been discharged one day earlier, having presented with an identical symptom complex; cystoscopy and left retrograde pyelogram had been negative. Furthermore, medical records showed that he had been admitted to numerous military medical facilities in the Philippines and Vietnam for identical reasons. Communications with the military psychiatric service showed that they were not interested in his future care and he was subsequently discharged from the hospital to return to active duty.

CASE 2. A 27-year-old single French-Canadian man reported that severe right colicky flank pain lasting for two hours had occurred while he was traveling between Vancouver, British Columbia, and Portland, Oregon. Gross hematuria during evaluation was noted in the patient in the emergency room. He claimed that studies had been done one month before admission for an episode of bilateral flank pain in Montreal, where microscopic hematuria was noted. Excretory urography

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resulted in an allergic reaction which he thought had required epinephrine. In addition, 2½ weeks earlier the patient had undergone litholapaxy for bladder stones (which he thought were uric acid in composition) and bilateral retrograde pyelograms, the results of which he did not know. He also admitted to several attacks of gouty arthritis, and an elevated level of serum uric acid treated with allopurinol and sodium bicarbonate.

Pertinent physical findings showed a normal temperature, right upper quadrant abdominal tenderness and guarding, and multiple venipuncture marks of the arms. Laboratory studies gave the following findings: leukocyte count, 6,900; 20 to 30 red blood cells per high power field on analysis of urine; greater than 10^5 alpha streptococcus and neisseria resembling respiratory flora on urine culture, and no calcification shown on a kidney, ureter and bladder study.

Our suspicions were aroused because of the preceding patient and we scheduled a cystoscopy and right retrograde pyelogram. When the anesthesiologist opened the patient's mouth, he exclaimed that the buccal mucosa looked like raw hamburger, this having most likely been self-induced to produce the blood for his factitious hematuria. In retrospect it is apparent that all of the patient's urine specimens had been collected in private. Cystoscopy showed bilaterally clear efflux but an edematous and inflamed right ureteral orifice. A right retrograde pyelogram showed no abnormality. A telephone call to Vancouver General Hospital gave the information that the patient had undergone a stone basketing attempt of the distal right ureter just the preceding day. When confronted with these facts, the patient admitted that he had succeeded in traveling from South Africa to Canada, journeyed across Canada and now was in the process of migrating southward along the West Coast of the United States by frequenting many hospitals with the above history (in order to receive free lodging). He was discharged and telephone warnings about this case were made to the urology services at the University of Oregon and the University of California at San Francisco.

CASE 3. A 48-year-old black man was seen in the emergency room with complaint of colicky left flank and abdominal pain, bloody urine and blood loss from the nose. He claimed to be a minister and also the president of the University of Nicaragua on a lecture tour from Mexico City to Vancouver. He stated that the previous day hospital admission had been required in Mexico City while passing two uric acid calculi, a third stone having been basketed from his distal left ureter. His past medical history was pertinent in that he claimed "factor 9 deficiency haemophilia," gout for which he was currently taking allopurinol and sodium bicarbonate, and recurrent uric acid calculi. He reported having passed six stones in the past 15 years and having several stones basketed in London 10 years ago while on a speaking tour. He claimed allergies to penicillin, morphine and iodinated contrast materials, the latter manifested by "bronchospasm and cardiac arrest."

On physical examination the patient was noted to be obese and in moderate distress with left costovertebral angle and left-sided abdominal tenderness. He was afebrile. There were bilateral anterior thigh masses which the patient claimed were silastic "pillows" placed to allow painless intramuscular injections. Pertinent laboratory data included leukocyte count, 4,800; hematocrit reading, 41 percent; blood urea nitrogen, 9 mg per 100 ml; factor 9, 100 percent activity; gross hematuria with clots on analysis of urine, and no abnormalities shown on kidney, ureter and bladder study.

On the morning after admission, while telephone calls were being made to substantiate the patient's identity, he informed the charge nurse that he had just learned that his grandmother and eight nieces and nephews had been killed in an automobile accident in Nicaragua. He then promptly disappeared down the back stairs of the hospital. Two days later a phone call was received from a hospital in Chico, California. They had admitted a patient with the same name and a similar story. The patient said he had been a patient in a Seattle hospital, but could not recall the hospital's name.

CASE 4. A 33-year-old woman, having just recently arrived in Seattle from Puerto Rico, was admitted for acute onset of severe left flank pain radiating to her left lower abdomen. Urological history indicated recurrent ureteral calculi for the past 16 years. One stone in the left ureter required basketing. A right nephrectomy was done three years previously for calculi, but when inadvertently a "cancer of the kidney" was discovered at operation, the right ovary and part of the soft tissue of the right thigh were also resected. She

received postoperative radiation therapy. Additional operations included four exploratory laparotomies for bowel obstruction, cholecystectomy, appendectomy, six incisional herniorrhaphies, partial resection of the left upper arm for a malignant lesion, and numerous local excisions of sebaceous cysts. She reported having multiple allergies including intravenous pyelogram dye (which caused "shock"), meperidine, pentazocine hydrochloride, codeine and penicillin.

On physical examination, the patient was noted to be obese and afebrile. Examination of the abdomen showed moderate left costovertebral angle tenderness and a right flank scar, multiple abdominal scars and decreased bowel sounds. Surgical scars were noted on the left arm and right thigh, and there were numerous smaller scars on the patient's body. Laboratory data included leukocyte count, 4,000; hematocrit reading, 33 percent; serum calcium, 8.6 mg per 100 ml; serum uric acid, 5.5 mg per 100 ml; +1 protein and 30 red blood cells and 20 leukocytes on high power field on analysis of urine. Radiopaque densities in the region of the left kidney and midureter were noted on kidney, ureter and bladder study.

Frequent large doses of morphine were required for control of pain. Additional oblique abdominal films appeared to project the radiodensities outside of the expected course of the left collecting system. On closer examination these appeared to be calcified subcutaneous nodules located under scars, presumably self-inflicted. Also an iodohippurate sodium ^{131}I renogram and technetium 99m DMSA (2,3-dimercaptosuccinic acid) renal scan showed a normal left kidney with no evidence of obstruction of the collecting system. The body temperature was recorded at 40°C (104°F), with a corresponding pulse of 80. The temperature was taken again 10 minutes later with a nurse in attendance and was found to be 37.7°C (99.86°F); 15 minutes later it was 37°C (98.6°F). The patient discharged herself at this point stating that every other doctor had been able to help her and that we were not. She also complained that she was not getting adequate pain medication.

Two days after discharge the patient reappeared in another Seattle training hospital complaining of acute left flank pain of two hours duration with the similar allergy history and was given 10 mg of morphine for a suspected left ureteral calculus seen on the kidney, ureter and bladder study. Analysis of urine showed 40 red blood cells per high power field. She was discharged from the emergency room feeling much improved but returned four days later with the same presenting complaint. She had severe left costovertebral angle tenderness on examination, and was afebrile. Analysis of urine again showed microscopic hematuria of 20 to 30 red blood cells per high power field. She refused urethral catherization to obtain a bladder specimen and immediately left the emergency room.

Discussion

There are three characteristic features of Munchausen syndrome which differentiate it from malingering or hysteria:[5]

(1) Imposture is a characteristic. The patients' stories are frequently bizarre, describing fantastic past experiences and unusual life-styles—much as one of our patients claimed to be the president of the University of Nicaragua.

(2) Their lives have been documented as homeless by many authors. They wander either widely as our four patients did or they may stay in one general region as did the patient in the case reported by Ireland, Sapira and Templeton[4] who visited 72 hospitals in Pennsylvania, New York and New Jersey in a period of 16 years.

(3) These patients matter of factly accept certainly painful and potentially dangerous diagnostic and operative procedures in order to preserve their "cover." This masochistic, self-destructive behavior is not seen in malingerers or hysterics.

The motives of these patients are unclear. Were it not for their masochistic acceptance of dangerous procedures, one might believe them to be performing or acting to amuse and impress themselves. Some might merely desire lodging, narcotics or a haven from law enforcement authorities, and some might simply wish to outwit unsuspecting physicians. Yet most of them manifest a need for pain and perhaps even punishment. They frequently show hostile, evasive and truculent behavior on the ward, and the pronounced chronicity of their behavior suggests severe sociopathic patterns.

Patients with Munchausen syndrome presenting with factitious ureteral calculi may have some of the following common factors, which were seen in our patients: (1) They may claim a past history of radiolucent calculi with the possible association of gout or hyperuricemia (or both) for which

they are taking allopurinol and urinary alkalinizing agents. (2) They may admit to a severe allergic reaction to iodinated contrast materials. (3) They may also claim allergies to other medications including narcotics in order to lend credence to the intravenous pyelogram dye allergy or to avoid suspicion of any drug addiction. (4) A past history of urological procedures with even the presence of appropriate scars may be found supporting their history of urolithiasis. (5) Generally, the use of narcotics is sporadic and not characteristic of narcotic addiction, with withdrawal symptoms rarely occurring. (6) These patients are usually very intelligent and anticipate the questions and answers of young inexperienced and unsuspecting house officers.

The goals of physicians dealing with these patients ought to be first to make the diagnosis and then avoid any further diagnostic or surgical procedures. Psychiatric evaluation and psychotherapy are essential in trying to remedy this behavior pattern, but frequently the patients leave the hospital against advice before this can be accomplished.

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Diagnosing Appendicitis in Children

. . . One can almost categorically say that if a child has localized physical findings in the right lower quadrant, then he has appendicitis unless you can prove he has something else. And I think that's the only important finding. No matter what the white count shows, no matter what the other laboratory tests show, localized physical findings in the right lower quadrant in the form of direct tenderness, rebound tenderness and spasm are indications of acute appendicitis and unless otherwise indicating some other diagnosis, one should proceed with treating the appendicitis with an appendectomy.

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